

# go-active claim form



To help us process your claim promptly please complete sections A and B and remember to sign and date the declaration. Please also enclose your original named receipt and verify the receipt amount in section B.

### Section A - About you

Full name (enter in box below)  Mr / Mrs / Miss / Ms  Policy number  S  P

Date of birth  D  D -  M  M -  Y  Y  Y  Y

Address  Telephone

**If you have changed your name or address in the last 5 years, please state**

Previous name

Previous address

Postcode     -    Previous postcode     -

Employer's name

If the claim is for a dependant child and they are covered by your go-active scheme please enter their details below:

Master/Miss\* Surname  Forename

Date of birth  D  D -  M  M -  Y  Y  Y  Y

\*Delete as appropriate

### Section B - Claims for treatment

**Please attach the relevant receipt (or receipts if claiming for more than one treatment) and complete the section below. Please ensure you return your completed claim form within 6 months from the first date of treatment. Receipts for dependant children must be in their name and separate to the policyholder. All receipts must be in the name of one person only.**

Please tick the box(es) that you wish to claim for and attach receipt(s)

Optical <input type="checkbox"/>	Dental <input type="checkbox"/>	Physiotherapy <input type="checkbox"/>	Osteopathy <input type="checkbox"/>
Chiropractic <input type="checkbox"/>	Acupuncture <input type="checkbox"/>	Hospital consultation fees <input type="checkbox"/>	Health screening <input type="checkbox"/>

Total receipt amount (in figures) £  (in words)

**Important: If you have a Sovereign Health Care cash plan in addition to this go-active scheme, we will process your claim against both policies where appropriate. This will ensure you receive the maximum allowable from both policies. Please note that the total claim paid from both policies cannot exceed the total amount paid by you. If you have a Sovereign Health Care cash plan please enter the policy number here:**  S  P

### Declaration

I confirm that the amount(s) shown on the attached receipt(s) are only for those charges incurred by myself or on behalf of my dependant child. I also confirm that the claim made is in accordance with the terms and conditions in my policy summary. Dental claims are for treatment only and are not for any patient plan, other type of insurance or dental maintenance materials such as toothbrushes, mouthwash, floss etc.

Signed  Date  D  D -  M  M -  Y  Y  Y  Y

Office use only

Please return your completed claim form and original named receipt(s) in an envelope to Sovereign Health Care, Royal Standard House, 26 Manningham Lane, Bradford BD1 3DN. Please remember to affix the appropriate postage stamps to the envelope.

**If you have any questions please contact the Sovereign Health Care claims team on 01274 841160. Lines are open Monday to Thursday 9am to 5pm and Friday 9am to 4pm.**